Freedom Psychiatry

Referral FORM to Receive Services Outside from Freedom Psychiatry

Date: _____

To: _____
Clinic Name Fax Number

From: _____
Person Sending Fax Fax Number

Reason for Referral:

_____

_____

Referring Provider: _____

Consulting Provider: _____
Freedom Psychiatry is Seeking Fax Number

Patient Name: _____ **DOB:** _____

Address: _____

Contact Number: _____
Clinic Name Fax Number

Patient's Release Information: *I authorize this referral source to share this form with Freedom Psychiatry Services PLLC for the purpose of discussing and scheduling my appointment. An additional release of information will be required to discuss treatment.*

_____ _____
Patient Signature **Date**

☐ Please check box if patient provided verbal consent.

Primary Insurance: _____

Policy/Group #: _____

Please send Demographics and notes along with this form.

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